Application for Waiver of Grounds of Excludability
Under Sections 245A or 210 of the Immigration and Nationality Act

I-690 Instructions

Please carefully read all of the instructions.
The fee will not be refunded.

1. ***Filing the Application***
The application and supporting documentation should be taken or mailed to an American Consulate if the applicant is outside of the United States and is applying for temporary resident status as a Special Agricultural Worker.

   If the applicant is in the United States, a participating Qualified Designated Entity near your place of residence, or

   The Service legalization office having jurisdiction over the applicant's place of residence or employment.

2. ***Fee***
A fee of thirty-five dollars ($35.00), is required at the time of filing. The fee is not refundable regardless of the action taken on the application.

   A separate cashier's check or money order must be submitted for each application. ***All fees must be submitted in the exact amount.*** The fee must be in the form of a cashier's check or money order. No cash or personal checks will be accepted. The cashier's check or money order must be made payable to "Immigration and Naturalization Service" unless applicant resides in the Virgin Islands or Guam. (Applicants residing in the Virgin Islands make cashier's check or money order payable to "Commissioner of Finance of the Virgin Islands." Applicants residing in Guam make cashier's check or money order payable to "Treasurer, Guam."

   A fee is not required if this application is filed for an alien who:

   Is afflicted with tuberculosis;
   Is mentally retarded; or
   Has a history of mental illness.

3. ***Applicants with Tuberculosis.***
An applicant with active tuberculosis or suspected tuberculosis must complete Statement A on page two of this form. The applicant and his or her sponsor is also responsible for having:

   Statement B completed by the physician or health facility which has agreed to provide treatment or observation, and

   Statement C, if required, completed by the appropriate local or state health officer.

   This form should then be returned to the applicant for presentation to the consular office, or to the appropriate office of the Immigration and Naturalization Service.

   Submission of the application without the required fully executed statements will result in the return of the application to the applicant without further action.

4. ***Applicants with Mental Conditions.***
An alien who is mentally retarded or who has a history of mental illness shall attach a statement that arrangements have been made for the submission of a medical report, as follows, to the office where this form is filed:

   The medical report shall contain:

   A complete medical history of the alien, including details of any hospitalization or institutional care or treatment for any physical or mental condition;

   Findings as to the current physical condition of the alien, including reports of chest X-rays and a serologic test if the alien is 15 years of age or older, and other pertinent diagnostic tests; and

   Findings as to the current mental condition of the alien, with information as to prognosis and life expectancy and with a report of a psychiatric examination conducted by a psychiatrist who shall, in case of mental retardation, also provide an evaluation of intelligence.

   For an alien with a past history of mental illness, the medical report shall also contain available information on which the United States Public Health Service can base a finding as to whether the alien has been free of such mental illness for a period of time sufficient in the light of such history to demonstrate recovery.

   The medical report will be referred to the United States Public Health Service for review and, if found acceptable, the alien will be required to submit such additional assurances as the United States Public Health Service may deem necessary in his or her particular case.

OMB #1115-0132

U.S. Department of Justice
Immigration and Naturalization Service

Application for Waiver of Grounds of Excludability
(Sec. 245A or Sec. 210 of the Immigration and Nationality Act)

Please begin with item #1, after carefully reading the instructions.

The block below is for *Government Use Only.*

Name and Location (City or Town) of Qualified Designated Entity	Fee Stamp
	Fee Receipt No. (This application)
Qualified Designated Entity I.D. No.	File No. (This applicant) A -

Applicant: Do not write above this line. See instructions before filling in application. If you need more space to answer fully any question on this form, use a separate sheet and identify each answer with the number of the corresponding question. *Fill in with typewriter or print in block letters in ink.*

1. **Family Name** *(Last Name in CAPITAL Letters)* *(First Name)* *(Middle Name)*	2. **Date of Birth** *(Month/Day/Year)*
3. **Address** *(No. and Street)* *(Apt. No.)* *(City/Town)* *(State/Country)* *(ZIP/Postal Code)*	
4. **Place of Birth** *(City or Town and County, Province or State)* *(Country)*	5. **Social Security Number**
6. **Date of visa application** *(Month/Day/Year)*—for: ☐ Permanent ☐ Temporary Residence	7. **Visa applied for at:**

8. **I am inadmissable under Section(s):** ☐ 212 (a) (1) ☐ 212 (a) (3) ☐ 212 (a) (6) ☐ 212 (a) (12) ☐ 212 (a) (19) ☐ Other 212 (a) *Specify Section (* _____ *)*

9. **List reasons of excludability; if active or suspected tuberculosis, the reverse of the page must be completed.**

10. **List all immediate relatives in the United States (parents, spouse and children):**

Name	Address	Relationship	Immigration Status

11. **I should be granted a waiver because:** *(Describe family unity considerations or humanitarian or public interest reasons for granting a waiver)* If more space is needed attach an additional sheet.

12. **Applicant's Signature**	13. **Date** *(Month/Day/Year)*

I&NS USE ONLY

Recommended by:

(Print or Type Name and Title) _____ *Date* _____

Signature _____ *I.D.#* _____ *Director, Regional Processing Facility* _____

A. APPLICANT

Instructions: Leave this side *blank* if your Application for Waiver of Grounds of Excludability is for any reason *other than* active or suspected *tuberculosis*. If your application is due to active or suspected tuberculosis, take this form to any physician or medical facility under contract with the Immigration and Naturalization Service. Have the physician complete Section B. You must sign Section A (below) *in the presence of the physician*.

If medical care will be provided by a physician who checked Box 3 or 4 in Section B, have Section C completed by the local or State Health Officer who has jurisdiction in the area where you reside. Present the form to the Health Officer after Sections A and B on this side, and *all sections on the other side* have been completed.

Statement: I have reported to the physician or health facility named in Section B; have presented all X-Rays used in the Legalization medical examination to substantiate diagnosis; will submit to such examinations, treatment, isolation, and medical regimen as may be required; and will remain under the prescribed treatment or observation whether on inpatient or outpatient basis, until discharged at the discretion of the physician named, or a physician representing the facility named in Section B. Satisfactory financial arrangements have been made. **(NOTE: This statement does not relieve you from submitting evidence to establish that you are not likely to become a public charge.)**

A. Signature of Applicant	*Date*

B. PHYSICIAN OR HEALTH FACILITY

Instructions: This section of Form I-690 may be executed by a physician in private practice (under contract with the Immigration and Naturalization Service), or a physician employed by a health department, other public health facility, or military hospital.

Complete Section B (below) of this form, and have alien sign and date Section A (above) *in your presence. Please be sure the alien's signature above, and the alien's signature on the other side of this form* ***are identical.***

Statement: I agree to supply any treatment or observation necessary for the proper management of the alien's tuberculous condition. I agree to submit Form CDC 75.18 to the health officer named below (*Section C) within thirty (30) days of the alien's reporting for care, indicating presumptive diagnosis, test results, and plans for future care of the alien. Satisfactory financial arrangements have been made.

I represent *(enter X in the appropriate box and type or legibly print name and address of facility):*

1. ☐ Local Health Department
2. ☐ Military Hospital
3. ☐ Other Public Health Facility
4. ☐ Private Practice or Private Health Facility under contract with the Immigration and Naturalization Service.

B. Signature of Physician	*Date*
Print or Type Name and Address of Physician and Facility. (If military, enter name and address of receiving hospital and mail directly to Centers for Disease Control, Atlanta, GA 30333.)	

C. LOCAL OR STATE HEALTH OFFICER

Instructions: If the facility or physician who signed in Section B is not in your health jurisdiction and is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction of the facility or physician prior to endorsing this document.

Statement: This endorsement signifies recognition of the physician or facility for the purpose of providing care for tuberculosis.

C. Signature of Health Officer	*Date*
Print or Type Name of Health Officer*, and Offical Name and Complete Address of Local Health Department.	

Form 1-690 (02/14/87)